IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
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Boise, Idaho 83720-0036
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August 27, 2009

Rex Redden
Idaho Falls Group Home #2 Wanda
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #2 Wanda, provider #13G029

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho Falls Group Home #2 Wanda, which was conducted on August 21, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **September 9, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by September 9, 2009. If a request for informal dispute resolution is received after September 9, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

Michael A Case, LSW

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G029	A. BUILDING _____ B. WING _____	08/21/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #2 WANDA	4360 WANDA STREET AMMON, ID 83406

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Lead Matt Hauser, QMRP Common abbreviations/symbols used in this report are: HRC - Human Rights Committee IDT - Interdisciplinary Team ITTP - Interdisciplinary Treatment Team Plan MAR - Medication Administration Record QMRP - Qualified Mental Retardation Professional	W 000		
W 111	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to maintain a record keeping system that contained consistent, accurate and comprehensive information. This failure directly impacted 5 of 8 individuals (Individuals #2, #3, #4, #6, and #7) whose Incident Reports and/or medical records were reviewed, and had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in a lack of documentation of Administrator notification of injuries of unknown origin, accurate Physician's Orders, and accurate Medication Administration Records. The findings	W 111	RECEIVED SEP 14 2009 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Ellis — TITLE: Admin Dir. — (X6) DATE: 9/8/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 111	Continued From page 1 include: 1. The facility's Resident Abuse and Neglect policy, revised 12/8/08, stated staff were to immediately report all incidents of abuse, neglect, mistreatment, or injuries of an unknown source to the Administrator. The facility's incident reports from 4/1/09 to 8/18/09 were reviewed and showed a failure to document Administrator notifications as follows: - 4/19/09 at 4:40 p.m. Individual #4 was noted to have redness, swelling, and bleeding from a scrape on his nose of an unknown origin. The incident report did not include documentation of Administrator notification. - 5/29/09 at 3:00 p.m. Individual #3 was noted to have a red mark and swelling on her forehead of an unknown origin. The incident report did not include documentation of Administrator notification. - 6/28/09 at 6:30 p.m. Individual #4 was noted to have a bruise of unknown origin. The incident report did not include documentation of Administrator notification. - 7/1/09 at 7:15 p.m. Individual #6 was noted to have a scratch on his back of an unknown origin. The incident report did not include documentation of Administrator notification. - 7/16/09 at 5:45 a.m. Individual #3 was noted to have scratches on her ear and chest of an unknown origin. The incident report did not include documentation of Administrator notification.	W 111	W 111 1. All individuals have the potential to be affected by this practice. All abuse, neglect, mistreatment, or injuries of an unknown source will be immediately reported to the Administrator Designee. The date and time of the notification to the Administrator Designee will be documented on the injury report by the individual who reported it. All staff will be retrained by the Home Supervisor and/or QMRP on the Resident Abuse and Neglect policy and proper documentation and notification practices. Anytime there is a medication change for an individual, the Medical Coordinator will review the medication change to ensure the individual is receiving the appropriate dosage. The Medical Coordinator will then incorporate the medication change onto the recap orders. The medication administration record will then be created based upon the information provided from the recap orders. The Health Care Assistant will then double check the medication administration record against the recap orders to ensure that documentation is accurate. 2. The QMRP will review all injury reports to ensure that documentation of the immediate notification to the Administrator Designee for all abuse, neglect, mistreatment, or injuries of an unknown source occurred. The Medical Coordinator will be responsible for reviewing all medication changes to ensure the individual is receiving the appropriate dosage. The Medical Coordinator will then be responsible for ensuring that all medication administration records contain accurate information based off the recap orders. The Health Care Assistant will be responsible for double checking the medication administration records against the recap orders to ensure the documentation is accurate. 3. Target date for completion will be October 21, 2009.	

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W 111	Continued From page 2 - 8/5/09 at 8:10 a.m. Individual #2 was noted to have scratches on his upper right arm of an unknown origin. The incident report did not include documentation of Administrator notification. - 8/8/09 at 7:00 a.m. Individual #7 was noted to have bleeding from her nose of an unknown origin. The incident report did not include documentation of Administrator notification. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the QMRP stated staff would immediately contact the QMRP with regards to injuries of unknown origin. The QMRP was the Acting Administrator at times and could receive the calls for notification. When not the Acting Administrator, the QMRP would immediately contact the Administrator or Administrator Designee with the information for notification. The QMRP stated these contacts were not documented. When asked during an interview on 8/21/09 from 1:50 - 1:55 p.m., the Administrator and Administrator Designee both stated they were immediately contacted by the QMRPs for all injuries of unknown origin but did not document the contact. The facility failed to ensure all required Administrator notifications were documented. 2. Individual #2's 4/28/09 ITTP stated he was a 30 year old male whose diagnoses included profound mental retardation, sleep disorder, and seizure disorder.	W 111		

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W 111	Continued From page 3 a. Individual #2's 11/08 MAR documented he received imipramine 25 mg 3 tables, for a total of 75 mg. His 12/2/08 Physician's Orders recap stated he received Imipramine 75 mg 3 tablets, for a total of 225 mg. The record did not contain documentation the dosage had been increased. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the Medical Coordinator stated she created the Physician's Orders recap, and the recap was inaccurate. b. Individual #2's record contained a physician's prescription, dated 2/2/09, which stated he was to received Imipramine 100 mg at bedtime. His 7/6/09 Physician's Orders recap stated he received Imipramine 300 mg each night. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the Medical Coordinator stated she created the Physician's Orders recap, and the recap was inaccurate. The facility failed to ensure Individual #2's Physician's Orders contained accurate information. 3. Refer to W365 as it relates to the facility's failure to ensure medication administration records contained accurate information.	W 111		
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by:	W 130		

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W 130	Continued From page 4 Based on observation and staff interview, it was determined the facility failed to ensure each individual was provided privacy during treatment and care of personal needs. This failure directly impacted 2 of 8 individuals (Individuals #1 and #8), and had the potential to impact 8 of 8 individuals (Individual #1 - #8) attending the facility's day treatment program. This resulted in individuals being assisted with medication administration activities in full view of other individuals attending and working at the day treatment program. The findings include: 1. An observation was conducted at the facility's day treatment program on 8/19/09 from 11:55 a.m. - 12:40 p.m. The lunch area of the day treatment program consisted of a rectangular area with four long tables set up allowing multiple individuals to sit down at the same time. At one end of the area, a kitchen was connected by a doorway with a solid door and an uncovered pass through window that was approximately 3 foot wide by 4 foot high. At 12:05 p.m., a staff took Individual #8 into the kitchen. Staff opened a locked tool box and removed a medication blister pack from the box, handed the blister pack to Individual #8, asked Individual #8 the day of the month, and punched a pill into applesauce which Individual #8 fed to herself. At the time Individual #8 was being assisted with her medications, Individual #1, Individual #3, Individual #6, 3 individuals from other facilities, 5 day treatment staff, and both surveyors were in the lunch area with a clear view of Individual #8. At 12:10 p.m., staff walked Individual #8 out of the	W 130	W 130 1. All individuals have the potential to be affected by this practice. A table will be purchased by the Administrator for the sole purpose of assisting individuals with self administration of medication programming in a more private area. 2. The Administrator will be responsible for purchasing a table that is used for the sole purpose of assisting individuals with self administration of medication programming in a more private area. The QMRP and supervisor of the facility will conduct observations anytime they are in the facility to ensure that staff are maintaining privacy during self administration of medication programming. 3. Target date for completion will be October 21, 2009.	

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W 130	Continued From page 5 kitchen and walked Individual #1 into the kitchen. During that time, Individual #7 entered the lunch area. Once Individual #1 was seated in the kitchen, the staff assisting with medication administration requested gloves from a co-worker through the pass through window. Individual #1 was assisted to administer her medications. Individual #3, Individual #6, Individual #7, Individual #8, 3 individuals from other facilities, 5 day treatment staff, and both surveyors were in the lunch area with a clear view of Individual #1. When asked how privacy was afforded to individuals during medication administration activities at the day treatment facility, the Day Treatment Supervisor, who was present during the observation, stated the kitchen door was to be closed during medication administration activities. When asked about the pass through window, the Day Treatment Supervisor stated she hand not thought about people being able to see through the pass through window. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the QMRP stated the pass through window in the kitchen at the day program facility prevented individuals from having privacy during medication administration activities. The facility failed to ensure Individual #1 and Individual #8 were afforded privacy at the day treatment facility during medication administration activities.	W 130		
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage	W 262		

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W 262	Continued From page 6 inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 2 of 4 individuals (Individuals #2 and #4) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approvals of restrictive interventions. The findings include: 1. Individual #2's 4/28/09 ITTP stated he was a 30 year old male whose diagnoses included profound mental retardation, sleep disorder, and seizure disorder. Individual #2's MAR, dated 7/09, documented he received Melatonin (an herbal drug) 4 mg at bedtime for sleep. However, Individual #2's record did not contain HRC approval for the use of Melatonin. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the QMRP stated HRC approval for Melatonin had not been obtained. The facility failed to ensure HRC approval was obtained for the use of Individual #2's Melatonin. 2. Individual #4's 2/26/09 ITTP stated he was a 16 year old male whose diagnoses included moderate mental retardation, autism, and Asperger syndrome with aggressive tendencies.	W 262	W 262 1. All individuals have the potential to be affected by this practice. Human Rights Committee consent will be obtained for all individuals requiring one-on-on staffing. Human Rights Committee consent will also be obtained for the use of any drug that has the potential for adverse side effects. 2. The QMRP will review the need for one-on-one staff and for the use of any drug that has the potential for adverse side effects and obtain consent from the Human Rights Committee members. The QMRP will review the need for one-on-one staffing and the use of drugs that have the potential for adverse side effects and receive consent from the Human Rights Committee members on a bi-annual basis. 3. Target date for completion will be October 21, 2009.	

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W 262	Continued From page 7 During an entrance conference on 8/17/09 from 8:50 - 9:30 a.m., the QMRP stated Individual #4 had one-on-one staffing due to aggressive behaviors. During observations at the facility on 8/18/09 from 3:35 - 4:30 p.m. and 8/19/09 from 11:55 a.m. - 12:40 p.m., Individual #4 was noted to have a designated one-on-one staff who remained with him at all times and in all locations of the facility, including Individual #4's bedroom and bathroom. Individual #4's record included a One-on-One Protocol, undated, which stated staff were to be no further than 10 feet from Individual #4, were to always be in the same room with Individual #4, and were not to provide assistance to other staff while acting as Individual #4's one-on-one. However, Individual #4's record did not include documentation HRC approval had been obtained for the use of one-on-one staffing. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the QMRP stated HRC approval had not been obtained for Individual #4's one-on-one staffing. The facility failed to ensure Individual #4's one-on-one staffing had been approved by the HRC.	W 262		
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.	W 263		

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W 263	Continued From page 8 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the parent/guardian for 2 of 4 individuals (Individuals #2 and #4) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior approvals for restrictive interventions. The findings include: 1. Individual #2's 4/28/09 ITTP stated he was a 30 year old male whose diagnoses included profound mental retardation, sleep disorder, and seizure disorder. Individual #2's MAR, dated 7/09, documented he received Melatonin (an herbal drug) 4 mg at bedtime for sleep. However, Individual #2's record did not contain written informed consent from the guardian for the use of Melatonin. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the QMRP stated written informed consent from the guardian for Melatonin had not been obtained. The facility failed to ensure written informed consent was obtained from Individual #2's guardian for the use of Melatonin. 2. Individual #4's 2/26/09 ITTP stated he was a 16 year old male whose diagnoses included moderate mental retardation, autism, and Asperger syndrome with aggressive tendencies. a. During an entrance conference on 8/17/09 from 8:50 - 9:30 a.m., the QMRP stated Individual	W 263	W 263 1. All individuals have the potential to be affected by this practice. The QMRP will review the need for one-on-one staffing and review the need for any drug that has the potential for adverse side effects with the individuals guardian and obtain written informed consent for the use of one-on-one staffing and/or drugs that have the potential for adverse side effects. 2. The QMRP will review the need for one-on-one staffing as well as any drug that has the potential for adverse side effects with the individuals guardian and will obtain written informed consent on an annual basis or as needed for any changes that may occur. 3. Target date for completion will be October 21, 2009.	

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W 263	Continued From page 9 #4 had one-on-one staffing due to aggressive behaviors. During observations at the facility on 8/18/09 from 3:35 - 4:30 p.m. and 8/19/09 from 11:55 a.m. - 12:40 p.m., Individual #4 was noted to have a designated one-on-one staff who remained with him at all times and in all locations of the facility, including Individual #4's bedroom and bathroom. Individual #4's record included a One-on-One Protocol, undated, which stated staff were to be no further than 10 feet from Individual #4, were to always be in the same room with Individual #4, and were not to provide assistance to other staff while acting as Individual #4's one-on-one. However, Individual #4's record did not include written informed consent from the guardian for the use of one-on-one staffing. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the QMRP stated written informed consent from the guardian had not been obtained for Individual #4's one-on-one staffing. b. Individual #4's record contained a Consent for Treatment, dated 2/28/08 and signed by the guardian, for the use of Depakote (an anticonvulsant drug) 1000 mg for aggression. The Consent for Treatment stated it was effective for one year. There was no additional documentation that written informed consent for Depakote had been renewed. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the QMRP stated written informed consent from the guardian for Depakote had not been renewed when the old consent	W 263		

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W 263	Continued From page 10 expired due to an oversight. The facility failed to ensure Individual #4's one-on-one staffing and use of Depakote for behavioral intervention was implemented only with written informed consent from the guardian.	W 263		
W 277	483.450(b)(1)(ii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive. This STANDARD is not met as evidenced by: Based on observation, review of the facility policies and procedures, record review, and staff interview it was determined the facility failed to ensure the mal-adaptive behavior policy included all positive and intrusive behavior interventions on a hierarchy ranging from most positive to most intrusive. This directly impacted 1 of 4 individuals (Individual #4) reviewed, and had the potential to impact 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in interventions being used without the necessary facility approvals. Findings include: The facility's Behavior Modification Program Guidelines, revised 9/19/06, listed approved interventions for maladaptive behaviors in a hierarchy divided into 6 levels. Increased staff supervision to one-on-one staffing was listed under Level 2. Level 1 and 2 interventions were not considered restrictive and did not require guardian consent and HRC approval.	W 277	W 277 1. All individuals have the potential to be affected by this practice. The Behavior Modification Program Guidelines will be revised to incorporate one-on-one staff supervision as a restrictive intervention which will require guardian consent and HRC approval. 2. The QMRP will revise the Behavior Modification Program Guidelines to incorporate one-on-one staff supervision as a restrictive intervention which will require guardian consent and HRC approval. The QMRP will continue to revise and update the Behavior Modification Program Guidelines on an as needed basis to ensure all positive and intrusive behavior interventions are addressed on the appropriate hierarchy. The QMRP will review the Behavior Modification Program Guidelines with the Human Rights Committee Members to ensure that the hierarchy ranges from most positive to most intrusive on a bi-annual basis. 3. Target date for completion will be October 21, 2009.	

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W 277	Continued From page 11 During an entrance conference on 8/17/09 from 8:50 - 9:30 a.m., the QMRP stated Individual #4 had one-on-one staffing due to aggressive behaviors. During observations at the facility on 8/18/09 from 3:35 - 4:30 p.m. and 8/19/09 from 11:55 a.m. - 12:40 p.m., Individual #4 was noted to have a designated one-on-one staff who remained with him at all times and in all locations of the facility, including Individual #4's bedroom and bathroom. Individual #4's record included a One-on-One Protocol, undated, which stated staff were to be no further than 10 feet from Individual #4, were to always be in the same room with Individual #4, and were not to provide assistance to other staff while acting as Individual #4's one-on-one. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the QMRP stated one-on-one staffing was restrictive and should be clarified in the policy. The facility failed to ensure one-one-one staff supervision was appropriately identified in the Behavior Modification Program Guidelines as a restrictive intervention.	W 277		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by:	W 312		

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W 312	Continued From page 12 Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were used only as comprehensive part of the individuals' ITTPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #2) whose medication reduction plans were reviewed. This resulted in an individual receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include: 1. Individual #2's 4/28/09 ITTP stated he was a 30 year old male whose diagnoses included profound mental retardation, sleep disorder, and seizure disorder. Individual #2's MAR, dated 7/09, documented he received Melatonin (an herbal drug) 4 mg at bedtime for sleep. However, Individual #2's record did not contain a medication reduction plan for Melatonin. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the QMRP stated a medication reduction plan for Melatonin did not exist. The facility failed to ensure Individual #2's Melatonin used for sleep was incorporated into a plan.	W 312	W 312 1. All individuals have the potential to be affected by this practice. Medication Reduction plans will be implemented for all drugs that have the potential for adverse side effects. 2. The QMRP will review all medications and implement medication reduction plans for those drugs that have the potential for adverse side effects. The treatment team will review all medication reduction plans on an annual basis or anytime a change has been made to a medication. 3. Target date for completion will be October 21, 2009.	
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.	W 362		

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W 362	Continued From page 13 This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the pharmacist conducted comprehensive drug regimen reviews with accurate input from the IDT for 1 of 4 individuals (Individual #2) whose pharmacy consultations were reviewed. This resulted in the potential for negative health outcomes due to inaccurate medication documentation. The findings include: 1. Individual #2's 4/28/09 ITTP stated he was a 30 year old male whose diagnoses included profound mental retardation, sleep disorder, and seizure disorder. Individual #2's MAR, dated 7/09, documented he received Imipramine (an antidepressant drug) 100 mg each night for sleep. Additionally, Individual #2's record included a physician's prescription, dated 2/2/09, that stated "Increase Imipramine to 4 (25 mg) tabs at bedtime." However, the Physician's Orders recap, dated 7/6/09, stated "Imipramine 100 mg 3 tabs." Individual #2's Pharmacy Review, dated 7/29/09, did not include the use of Imipramine and did not contain documentation that Individual #2's standing orders had been reviewed. Further, the dosage of Imipramine on the MAR and physician's prescription did not match the dosage of Imipramine on the Physician's Orders recap. When asked about the pharmacy review process, during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the Medical Coordinator stated the facility's nursing staff, QMRPs, Physician, and Pharmacist would meet on a quarterly basis and	W 362	W 362 1. All individuals have the potential to be affected by this practice. Anytime there is a medication change for an individual, the Medical Coordinator will review the medication change to ensure the individual is receiving the appropriate dosage. The Medical Coordinator will then incorporate the medication change onto the recap orders. The medication administration record will then be created based upon the information provided from the recap orders. The Health Care Assistant will then double check the medication administration record against the recap orders to ensure the documentation is accurate. Anytime a medication change occurs for any individual a copy of the original prescription order will be reviewed during pharmacy review by the team to ensure the appropriate dosage is documented appropriately on the pharmacy review form. 2. The Medical Coordinator will be responsible for reviewing all medication changes to ensure the individual is receiving the appropriate dosage. The Medical Coordinator will then be responsible for ensuring that all medication administration records contain accurate information based off the recap orders. The Health Care Assistant will then be responsible for double checking the medication administration records against the recap orders to ensure the documentation is accurate. The pharmacy review team will be responsible for ensuring that all new medications are documented appropriately on the pharmacy review form by reviewing a copy of the original prescription on a quarterly basis. 3. Target date for completion will be October 21, 2009.	

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W 362	Continued From page 14 review the Physician's Orders recaps, the MARS, and the Pharmacy Review form. The Medical Coordinator stated she created the Physician's Orders recap, the MAR, and the Pharmacy Review forms, and that original prescriptions and laboratory reports were not reviewed. By reviewing only information and documentation created by the Medical Coordinator, the IDT would not be able to ensure accurate and relevant input was provided during the pharmacy review process to identify and address discrepancies and potential dosage inaccuracies. Further, Individual #2's Pharmacy Review forms dated 10/22/08 and 1/21/09 both documented he received Imipramine 75 mg 3 tablets, for a total of 225 mg. However, his 11/08 MAR documented he received Imipramine 25 mg 3 tablets. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the Medical Coordinator stated the dosage listed on the pharmacy review was incorrect. The facility failed to ensure the IDT provided complete and accurate information during the pharmacy review process.	W 362		
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individual medication administration records were maintained for 1 of 4 individuals (Individual #2)	W 365		

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W 365	Continued From page 15 whose medication administration records were reviewed. This resulted in the potential for an individual to not receive medications as ordered by the physician. The findings include: 1. Individual #2's 4/28/09 ITTP stated he was a 30 year old male whose diagnoses included profound mental retardation, sleep disorder, and seizure disorder. Individual #2's record contained a physician's prescription, dated 2/2/09, which stated "Increase Imipramine to 4 (25 mg) tabs at bedtime." Individual #2's record included two MARs dated 2/09. The first 2/09 MAR documented medications received 2/1/09 - 7:00 a.m. on 2/3/09. The second 2/09 MAR documented medications received from 2/3/09 - 2/28/09. The first 2/09 MAR stated "Imipramine 75 mg 3 tabs" and the second 2/09 MAR stated "Imipramine 25 mg 4 tabs." The second 2/09 MAR documented a decrease in Imipramine rather than an increase. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the Medical Coordinator stated she created the MAR. The Medical Coordinator stated the first 2/09 MAR was incorrect and Individual #2 had been receiving Imipramine 75 mg, not 225 mg as indicated. Without accurate information being present on the MAR it would not be possible for the facility to ensure Individual #2 was receiving the correct amount of medication. Additionally, Individual #2's 12/08 and 1/09 MARs	W 365	W 365 1. All individuals have the potential to be affected by this practice. Each month the Medical Coordinator will prepare medication flow sheets in accordance with current physicians orders. The Medical Coordinator will review for accuracy and completeness before they are implemented into the med books. Anytime a medication change occurs the Medical Coordinator will document the change on the medication administration record and the Health Care Assistant will double check the changes to ensure that the medication change has been documented according to the original prescription. 2. The Medical Coordinator will be responsible for ensuring that all changes in medication are accurately documented on the medication administration record by comparing it to the original prescription. The Health Care Assistant will be responsible for double checking all changes made to the medication administration records to ensure that the medication change has been documented on the medication administration record accurately. 3. Target date for completion will be October 21, 2009.	

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W 365	Continued From page 16 both documented Individual #2 received Imipramine 75 mg 3 tablets. When asked during an interview on 8/21/09 from 10:45 a.m. - 12:00 p.m., the Medical Coordinator stated the MARs were incorrect. The facility failed to ensure Individual #2's medication administration records were accurately maintained.	W 365		
W 426	483.470(d)(3) CLIENT BATHROOMS The facility must, in areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit. This STANDARD is not met as evidenced by: Based on environmental review and staff interview, it was determined the facility failed to ensure hot water temperatures were maintained at or below 110 degrees Fahrenheit for 6 of 8 individuals (Individuals #1, #2, and Individuals #5 - #8) who were unable to regulate water temperatures independently. This resulted in an increased risk of scald injuries during hand washing and bathing. The findings include: 1. Hot water temperatures were obtained at the facility during an environmental review on 8/19/09 from 1:40 - 2:20 p.m. and were recorded as follows: Kitchen sink - 120.3 degrees Hallway bathroom - 121.2 degrees Medication bathroom - 120.9 degrees End of hallway bathroom - 120.7 degrees	W 426	W 426 1. All individuals have the potential to be affected by this practice. The Home Supervisor and Lead Worker will conduct weekly water temperature checks in the home. 2. The Home Supervisor and Lead Worker will be responsible for conducting weekly water temperature checks in the home. If the water temperature is above 110 degrees Fahrenheit they will immediately notify the Administrator Designee so water temperatures can be adjusted to the appropriate temperature. Maintenance Personnel will conduct monthly water temperature checks in the home to ensure the water temperature is below 110 degrees Fahrenheit. 3. Target date for completion will be October 21, 2009.	

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W 426	Continued From page 17 When asked if the individuals residing in the facility could regulate water temperatures, the Home Supervior, who was present, stated only Individuals #3 and #4 had some ability to self regulate water temperatures. At that time, the Home Superviosr was notified of the water temperatures being too high. The facility failed to ensure water temperatures were maintained at or below 110 degrees Fahrenheit. Note: Water temperatures were re-checked on 8/20/09 at 3:30 p.m. and found to be within the acceptable range.	W 426		

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MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.	MM194	MM194 Refer to W262	
MM196	16.03.11.075.10(c) Consent of Parent or Guardian Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and This Rule is not met as evidenced by: Refer to W263.	MM196	MM196 Refer to W263	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197	MM197 Refer to W312	
MM203	16.03.11.075.12(a) Treated with Consideration Treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs; and This Rule is not met as evidenced by: Refer to W130.	MM203	MM203 Refer to W130	
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such	MM380		

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MM380	Continued From page 1 character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: During an environmental survey conducted on 8/19/09 from 1:35 - 2:00 p.m., the following concerns were noted: - The sink in the bathroom across from the medication bathroom filled with water within 40 seconds, and drained slowly. - Toilet bolt covers were missing in the bathroom across from the medication bathroom. - Toilet bolt covers were missing in the medication bathroom. - Toilet bolt covers were missing in the bathroom at the end of the hallway. - The bedroom shared by Individual #2 and Individual #6 had two 2 and 1/2 inch by 1 inch holes, and five 1 and 1/2 inch by 1/2 inch holes in the wall above Individual #6's bed. - The medication cabinet contained multiple spills, and several medication containers were stuck to the shelves.	MM380	MM380 1. All individuals have the potential to be affected by this practice. All employees are responsible for completing a damage report on all repairs that are needed in the facility. The damage report is then turned in to the supervisor for review. The supervisor then submits the damage report to the QMRP for follow-up. 2. All repairs that are needed will be completed by maintenance personnel. All staff will be retrained by the Home Supervisor and Lead Worker on all deep cleaning duties. The Home Supervisor and Lead Worker will conduct a walk through of the home on a weekly basis to ensure deep cleaning duties and repairs of the facility are being preformed. 3. Target date for completion will be October 21, 2009.	

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MM380	Continued From page 2 - The shelves in the door of the refrigerator/freezer located in the kitchen were missing the rails, and makeshift rails had been fashioned out of duct tape. - A section of the light cover in the kitchen overhead light was missing. - The dining room wall near the first table had a 1 inch by 2 inch hole. - The back patio light was not functioning. The facility failed to ensure environmental repairs were completed.	MM380		
MM520	16.03.11.200.03(a) Establishing and Implementing polices The administrator will be responsible for establishing and implementing written policies and procedures for each service of the facility and the operation of its physical plant. He must see that these policies and procedures are adhered to and must make them available to authorized representatives of the Department. This Rule is not met as evidenced by: Refer to W277.	MM520	MM520 Refer to W277	
MM570	16.03.11.210.05(b) Meidcations and Treatments A record of all medications and treatments prescribed and administered; and This Rule is not met as evidenced by: Refer to W365.	MM570	MM570 Refer to W365	

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MM573	Continued From page 3	MM573	MM 573	
MM573	16.03.11.210.05(e) Health Care Complaints Notation record of the individual resident's health care complaints and problems together with evaluation and action followed. This Rule is not met as evidenced by: Refer to W111.	MM573	Refer to W111	
MM696	16.03.11.250.09(d)(i) Refrigerator and Freezer Each refrigerator and freezer must be equipped with a reliable, easily read thermometer. Refrigerators must be maintained at forty-five (45) degrees Fahrenheit or below. Freezers must be maintained at zero degrees - ten (0-10) degrees Fahrenheit or below. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure each refrigerator and freezer was equipped with a reliable, easily read thermometer for 8 of 8 individuals (Individuals #1 - #8) residing in the facility. This resulted in the potential for food to be stored at unsafe temperatures. The findings include: An environmental survey conducted on 8/19/09 from 1:35 - 2:00 p.m. During that time it was noted the freezer of the refrigerator/freezer combination in the kitchen was missing the thermometer. The freezer contained various items including frozen vegetables and frozen meats. All items appeared frozen and were solid. Additionally, the refrigerator of the refrigerator/freezer combination in the garage was missing the thermometer. The refrigerator contained various items including milk and dairy products.	MM696	MM696 1. All individuals have the potential to be affected by this practice. Thermometers have been purchased and have been placed in all refrigerators in the facility. 2. Maintenance personnel will check for placement of thermometers during monthly maintenance checks of the facility. If a thermometer is found to be missing, maintenance personnel will immediately purchase a new one for the facility. 3. Target date for completion will be October 21, 2009.	

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MM696	Continued From page 4 The Home Supervisor, who was present during the review, stated thermometers would be obtained for the facility. The facility failed to ensure each freezer was equipped with a reliable, easily read thermometer.	MM696		
MM758	16.03.11.270.02(f)(iv) Medication System Monitored The resident's medication system must be evaluated and monitored on a regular basis by a registered nurse and/or a licensed pharmacist. Such evaluations must be done at least every thirty (30) days and records of the evaluation, as well as action taken to correct noted problems, must be kept on file by the facility administrator. This Rule is not met as evidenced by: Refer to W362.	MM758	MM758 Refer to W362	